

REQUEST AND RELEASE OF MEDICAL INFORMATION TO COMMUNICATIONS MEDIA

For use of this form see AR 40-66; the proponent agency is the Office of The Surgeon General.

PRIVACY ACT STATEMENT

AUTHORITY: Section 3012, title 10, United States Code.

PRINCIPAL PURPOSE(S): This form provides for patient/parent/guardian consent to release requested personal medical information to news publication or broadcast.

ROUTINE USES: The requested information will be released on this form to the communications media. It will be used for news publication or broadcast.

MANDATORY OR VOLUNTARY DISCLOSURE: The release of this information is voluntary. There is no effect on the individual not providing the requested information.

SECTION I - PATIENT IDENTIFICATION

NAME (Last, First, Middle)			ADDRESS
AGE	SSN	STATUS	NAME OF MEDICAL TREATMENT FACILITY

SECTION II - TO BE COMPLETED BY REQUESTOR

I certify that I represent _____
(Name and Address of Communications Media)
and that medical information on the above identified patient is requested
for news publication or broadcast.

List specific information requested below:

DATE (YYYYMMDD)	SIGNATURE OF PUBLIC AFFAIRS OFFICER	SIGNATURE OF MEDIA REPRESENTATIVE
-----------------	-------------------------------------	-----------------------------------

SECTION III - TO BE COMPLETED BY PATIENT/PARENT/GUARDIAN

I, _____, hereby request and authorize the release of the requested
information concerning my illness or injury and hospital treatment (complete when other than patient gives consent - the illness
or injury and hospital treatment of (_____) while a patient in the medical treatment
facility, to the above mentioned communications media. I hereby agree to hold the hospital, its physicians, and its staff free and
harmless from any, and all liabilities or ill effects which might arise from the publication or broadcast of such information.

DATE (YYYYMMDD)	SIGNATURE OF WITNESS	SIGNATURE OF PATIENT/PARENT/GUARDIAN
-----------------	----------------------	--------------------------------------

SECTION IV - TO BE COMPLETED BY ATTENDING PHYSICIAN

Information as requested and authorized is hereby furnished:

DATE (YYYYMMDD)

SIGNATURE OF ATTENDING PHYSICIAN

SECTION V - TO BE COMPLETED BY PATIENT AND ADMINISTRATION DIVISION

Section I through IV have been reviewed and is ☐ approved ☐ disapproved for release.

DATE (YYYYMMDD)

SIGNATURE OF CHIEF, PATIENT ADMINISTRATION DIVISION (*or designated representative*)

Upon completion of this form, a copy will be placed in the patient's medical record and a copy will be returned to the Public Affairs Officer for release of the requested information to the media representative.